GEORGIA DEPARTMENT OF COMMUNITY HEALTH

EXPRESS SCRIPTS®
Charting the Future of Pharmacy

6625 W. 78th St., BW 1041
Bloomington, MN 55439
PH#: 1-800-650-9340

Statin Appeal
GA Dept. of Community Health Medicaid/PeachCare Program

FAX to: 1-877-852-4070 TODAY'S DATE:_____

Note: If the following information is NOT filled in completely, correctly, or legibly the appeal process **will** be delayed.
(One form per patient please)

Patient's Full Name _____

Patient's ID# _____ **Patient's DOB** _____

Medication Requested: _____ **Strength**_____ **Directions** _____

A COPY OF THE MEMBER'S LIPID PANELS MUST BE INCLUDED WHEN SUBMITTING

(both Pre-Treatment LDL Value/Date and Current LDL Value/Date are required to complete the review)

Diagnoses	Yes	No	Unknown
Coronary Heart Disease (CHD)			
Diabetes Mellitus			
Carotid Artery Disease			
Peripheral Arterial Disease			
Abdominal Aortic Aneurysm			
Previous Coronary Event (Myocardial Infarction, Angina, Arrhythmia)			

Risk Factors	Yes	No	Unknown
Age: M >45yrs, F >55yrs			
Hypertension (≥130/≥85 mmHg or on HTN medication)			
HDL cholesterol: M <40 mg/dL, F <50 mg/dL			
Family history of premature CHD in first degree relative: M <55yrs, F <65yrs			
Cigarette smoking			
Metabolic Syndrome			

	Yes	No	Unknown
Abdominal obesity (waist circumference: M >40in, F >35in)			
Triglycerides ≥150 mg/dL			
HDL: M <40 mg/dL, F <50 mg/dL			
BP ≥130/≥85 mmHg			
Fasting glucose ≥110 mg/dL			

☐ **Please check box if you are attaching page 2 with this member's appeal request.**

Physician Name_____

Physician Address_____

Physician Phone_____ **Physician Fax** _____

Physician Signature (Required)_____

Georgia Department of Community Health

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Patient's Name:_____ **ID#:**_____ **DOB:**_____

In the space below, please provide any further information certifying medical necessity for your patient to remain on current therapy.

Physician Signature (Required):_____ **Date:**_____